

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

THE UNITED STATES OF AMERICA PLAINTIF
VS. CIVIL NO. 3:16CV00622CWR-FKB
THE STATE OF MISSISSIPPI DEFENDANTS

TRIAL TRANSCRIPT
VOLUME 3

BEFORE THE HONORABLE CARLTON W. REEVES
UNITED STATES DISTRICT JUDGE
MORNING SESSION
JUNE 5, 2019
JACKSON, MISSISSIPPI

REPORTED BY: CHERIE GALLASPY BOND
Registered Merit Reporter
Mississippi CSR #1012

501 E. Court Street, Ste. 2.500
Jackson, Mississippi 39201
(601) 608-4186

1 APPEARANCES:

2 FOR THE PLAINTIFF: MR. MATHEW SCHUTZER
3 MS. REGAN RUSH
4 MS. DEENA FOX
MR. PATRICK HOLKINS

5 FOR THE DEFENDANT: MR. JAMES W. SHELSON
6 MR. REUBEN V. ANDERSON
MR. HAROLD PIZZETTA

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1 THE COURT: Good morning. I take it there's not an
2 announcement, so I guess we'll -- you have another 30 days or
3 so to tell me you have an announcement. Oh, and that's what I
4 tell every party throughout the course of any case. It's in
5 your hands until the -- in this case, until the juror or the
6 judge has ruled, but it's in your hands, and I encourage you
7 all to continue to try to get it resolved. I learned that from
8 a mighty wise person 30 years ago. You try to get it resolved.
9 Do that.

10 All right. But if you will, we're ready, I believe.
11 Are we ready to continue the testimony of Dr. Drake?

12 MR. HOLKINS: Yes, Your Honor.

13 THE COURT: All right. Dr. Drake, you may return to
14 the stand.

15 MR. HOLKINS: Your Honor, very briefly, before we get
16 started with Dr. Drake, I want to give you a quick road map for
17 the day.

18 THE COURT: Great.

19 MR. HOLKINS: We just have a few questions for
20 Dr. Drake on direct, and then we have relatively brief
21 testimony from our statistical expert, Dr. Todd MacKenzie.
22 After that, we hope to call the peer support specialist on our
23 witness list, let Melody Worsham, who is also a mental health
24 consumer.

25 THE COURT: Okay. Thank you. Dr. Drake, you're still

1 under oath. I'm not going to have you resworn. Your oath
2 yesterday still applies. All right. Thank you.

3 You may proceed, counsel.

4 MR. HOLKINS: Thank you, Your Honor.

5 ROBERT DRAKE,

6 having first been duly sworn, testified as follows:

7 DIRECT EXAMINATION (Continuing)

8 BY MR. HOLKINS:

9 Q Good morning, Dr. Drake.

10 A Good morning.

11 Q Let's pick up where we left off yesterday with your
12 aggregate findings. Could you turn to page 20 of your report,
13 which is the first tab in your binder.

14 A Okay.

15 Q Dr. Drake, you wrote on page 20, toward the top, that
16 patients returning to the community from State Hospitals are
17 not connected to permanent supported housing in other
18 recovery-oriented community-based services that would prevent
19 future hospitalizations. Is assertive community treatment one
20 of the services you were referring to?

21 A Yes.

22 Q Dr. Drake, please turn to the document marked PX-417 in
23 your binder. That's the fourth tab.

24 MR. HOLKINS: Your Honor, this document was
25 preadmitted into evidence.

1 THE COURT: Okay. Thank you.

2 BY MR. HOLKINS:

3 Q Dr. Drake, what is the title of this document?

4 A It says, "Client review members with program of assertive
5 community treatment recommendation and PACT team locations."

6 Q And what does that document show?

7 A It shows that for many of the clients in the review, there
8 was -- they did not live close or within the areas that were
9 providing PACT services. Yes, this graphic shows that many of
10 the patients in the client review lived in areas that were not
11 covered by PACT teams.

12 Q Let's return to your report in the second aggregate finding
13 on page 21.

14 A Okay.

15 Q I want to direct you to a line at the end of the last full
16 paragraph on page 21. You wrote, "Mississippi remains mired in
17 this early phase of deinstitutionalization." What from the
18 clinical review led you to conclude that?

19 A I think we discussed that the first phase of
20 deinstitutionalization moved people out of hospitals into ward
21 and care homes, family homes and nursing homes, and that was
22 prior to the use of assertive community treatment and other
23 community-based interventions. And we -- and during that
24 phase, many people cycled back and forth between the hospital
25 and the community. As we -- as states implemented more

1 community-based services, that cycling in and out of hospitals
2 reduced over time.

3 In Mississippi, in the 164 patients that we reviewed, we
4 found that many of them or the great majority of them could
5 have done better with a greater access to community-based
6 services.

7 Q Just to clarify, the number of individuals that you
8 reviewed for this case is 154?

9 A 154. Excuse me.

10 Q Have other states moved beyond this first phase of
11 deinstitutionalization?

12 A Yes.

13 Q Please turn to page 22 and your third aggregate finding.
14 You write that "Treatment and discharge planning at State
15 Hospitals in Mississippi do not involve the necessary
16 participants and processes to ensure speedy effective
17 transactions." You may have testified about this yesterday,
18 but could you briefly restate what are the necessary
19 participants in discharge planning?

20 A Well, in addition to the inpatient team, the patient, the
21 family and the outpatient team should be involved in planning
22 the transition.

23 Q Generally, which participants did you find were not
24 involved in discharge planning for the individuals in the
25 clinical review?

1 A Many of the patients were discharged with a call to the
2 community mental health center or an appointment sheet to the
3 community mental health center, but they had themselves not
4 been involved in the process, at least according to their
5 testimony and the hospital records, and we encountered almost
6 no families that had been involved in the process, even though
7 they were often the ones receiving the patients on discharge.

8 Q And why is the participation of family members and
9 community service providers important to ensuring speedy
10 effective transitions?

11 A Well, for many reasons, but the biggest one, I think, is
12 that when the community players are not involved, people often
13 get lost in the transition between the hospital and the
14 community. That is, they may have an appointment in their
15 hand, but they don't make the appointment. They may have some
16 medicines, but they don't get the prescriptions to -- so that
17 they have continuity of medications and, you know, other
18 reasons.

19 Q Are adults with serious mental illness who do not receive
20 effective discharge planning, as you've described it, at
21 greater risk of rehospitalization?

22 A Yes.

23 Q Dr. Drake, let's turn back quickly to something that
24 appears earlier in your report. This is on page 2 at the
25 bottom of the second full paragraph. You write that

1 "reasonable community-based services are scarce or
2 nonexistent," and you list examples of those reasonable
3 community-based services. Do you see where I am?

4 A Yes. Yes.

5 Q For what group of people in Mississippi did you find that
6 reasonable community-based services are scarce or nonexistent?

7 A For what group? The 154 patients when we reviewed.

8 Q I'd now like to turn to JX-60, which is the last tab in
9 your binder. We discussed this document yesterday. It is the
10 Mississippi Department of Mental Health's operational standards
11 for adult mental health services. Correct?

12 A Yes.

13 Q Have you reviewed this document?

14 A Yes.

15 Q When you reviewed it, did you recognize parts of it?

16 A Yes.

17 Q From where?

18 A Well, quite a bit of it comes from the language that we
19 wrote on evidence-based practices for SAMHSA years ago.

20 Q How would you compare the community-based mental health
21 services described in this document with what the people in the
22 clinical review were actually receiving?

23 A Well, the practices described are described well, and they
24 are -- they represent the core services that we believe and
25 SAMHSA believes and I think state leaders believe should be

1 available everywhere, but we found that people rarely had
2 access to these services, so the standards were not being
3 implemented or fulfilled, at least among the 154 patients whom
4 we reviewed.

5 Q Dr. Drake, looking back on your work for this case, what
6 lasting images from the clinical review will stay with you?

7 A What comes to mind as a -- the most poignant image in some
8 ways was visiting a large group home outside of Jackson where a
9 large number of men were sitting around in a very large day
10 room, and they were all rocking and shaking and drooling and
11 not communicating with each other or doing anything, and it
12 reminded me of State Hospital units that I had seen back in the
13 1970s, and it -- I'll stop there.

14 Q How did you react to that?

15 A Well, it really makes me very sad that situations like that
16 persist in the United States.

17 MR. HOLKINS: If I could, Your Honor, just confer with
18 counsel for one moment.

19 THE COURT: You may.

20 (Short Pause)

21 MR. HOLKINS: That's all the questions I have for
22 Dr. Drake at this time, Your Honor.

23 THE COURT: All right.

24 MR. SHELSON: May I proceed, Your Honor.

25 THE COURT: Yes, you may.

1 MR. SHELSON: Thank you, Your Honor.

2 CROSS-EXAMINATION

3 BY MR. SHELSON:

4 Q Good morning, Dr. Drake.

5 A Good morning.

6 MR. SHELSON: May I just flip this up?

7 BY MR. SHELSON:

8 Q All right. Dr. Drake, do you remember being asked about
9 this document yesterday?

10 A Yes.

11 Q Dr. Drake, I'd like to ask you about the far left bar
12 graph.

13 THE COURT: For the record, Mr. Shelson -- for your
14 record, which document is this?

15 MR. SHELSON: Thank you, Your Honor. That's -- unless
16 I'm mistaken, it's PDX-3.

17 THE COURT: All right. Thank you.

18 BY MR. SHELSON:

19 Q Dr. Drake, the far left column, is that "would have avoided
20 or spent less time in the hospital"?

21 A Yes.

22 Q Is that referring to State Hospitals?

23 A Yes.

24 Q Okay. So you agree with me that would have avoided or
25 spent less time two different things?

1 A Yes.

2 Q Okay. So by "would have avoided," do you mean would have
3 avoided hospitalization altogether?

4 A Yes.

5 Q And by "spent less time," do you mean that the individual
6 would have gone to a State Hospital but would have spent less
7 time there?

8 A Yes.

9 Q All right. As you testified yesterday, you reviewed seven
10 individuals in the sample of 154?

11 A As the first interviewer, yes.

12 Q Yes, sir. So with respect to those seven individuals, did
13 you differentiate how many of them would have avoided
14 hospitalization altogether versus how many would have went to
15 the hospital but spent less time there?

16 A Yes, I think so.

17 Q How did you do that?

18 A Well, there were at least two people in the -- among the
19 seven who had diagnoses of drug-induced psychosis, which is a
20 topic I've studied over the years, and people with that problem
21 rarely, rarely go to State Hospitals. The standard --

22 Q In your expert report in this case, you have a write-up on
23 each of the seven individuals you were the lead reviewer on.
24 Correct?

25 A Yes.

1 Q In those write-ups, did you differentiate between whether
2 the individual would have avoided hospitalization or would have
3 went to the hospital but spent less time there?

4 A I don't remember.

5 Q Is there any aggregate finding in your report about whether
6 the seven individuals would have avoided hospitalization
7 altogether or would have still went to the hospital but spent
8 less time there?

9 A Aggregate -- by aggregate finding, you mean the whole
10 sample?

11 Q For example, four would have avoided hospitalization
12 altogether, and three would have went to the hospital but spent
13 less time there?

14 A So you mean of the seven?

15 Q Yes, sir.

16 A I don't think I recall writing that in the report.

17 Q Do you -- did any of the other clinical review team members
18 do that?

19 A I don't recall.

20 Q Do you know whether the court has any way to know, of the
21 154 individuals, how many would have avoided hospitalization
22 altogether versus they would have went to the hospital but
23 spent less time?

24 A You're asking me whether the court has some way to know the
25 answer to that?

1 Q Based on the reports of the CRT members in this case.

2 A Again, I don't recall that that's in the report.

3 Q This is a minor point, Doctor, but why does this say
4 "client-specific findings"?

5 A I think that refers to the findings on the seven clients
6 that I was the first interviewer for.

7 MR. ANDERSON: Your Honor, just a moment. I'm having
8 difficulty hearing the doctor. He needs to speak louder or
9 into the microphone. My hearings aids are working.

10 A I'll try. Thank you.

11 BY MR. SHELSON:

12 Q Doctor, in what sense are the 154 individuals clients?

13 A Pardon me?

14 Q In what sense are the 154 individuals clients?

15 A Oh, well, in the mental health field, people who use mental
16 health services are referred to by different terms, and
17 sometimes, especially in hospitals, they are called patients,
18 and sometimes, or predominantly in community mental health,
19 they're called clients, and sometimes they're referred to by
20 other terms.

21 Q Did you establish the doctor-patient relationship with any
22 of the 154 clients in the sample?

23 A Do you mean was I the treating doctor with any of them?

24 Q Or did you, in any other sense, establish the
25 doctor-patient relationship with any of them?

1 A I'm not sure what you mean by that.

2 Q Okay. I'll move on. Doctor, at some point, all 154
3 individuals in the sample were hospitalized in a State Hospital
4 at least once. Is that correct?

5 A Yes.

6 Q All right. At the time that they were admitted, were they
7 appropriate for admission?

8 A I believe that they were all civilly committed so that a
9 court -- I believe the process in Mississippi is that a court
10 has to be involved in that process.

11 Q Do you know what the criteria are for admission to a State
12 Hospital in Mississippi?

13 A I believe that I'd read that, and I believe that it refers
14 to immediate dangerousness or -- to self or others.

15 Q To your knowledge, is that a common standard for admission
16 to State Hospitals among the states?

17 A Yes, I think so.

18 Q Doctor, I'm going to show you PDX-1, which you talked about
19 a little bit yesterday. Do you recall that document?

20 A Yes.

21 Q All right. In the mental health field, what does an
22 occupational therapist do?

23 A Occupational therapists are often involved in helping
24 people learn the skills for basic living and taking care of
25 their apartment and finding a job and, and that's basically it.

1 Q What do certified psychiatric rehabilitation practitioners
2 do?

3 A They -- that varies tremendously, but in general,
4 rehabilitation specialists are experts in helping people to
5 develop skills, helping them to develop support systems, and
6 helping them to improve their functioning in the community.

7 Q And generally speaking, at least what do licensed clinical
8 social workers do?

9 A Again, a variety of interventions, but they are often
10 involved in psychotherapy kinds of activities and in working
11 with families.

12 Q Do you recall yesterday giving some testimony about
13 medications, particularly antipsychotic medications?

14 A Yes.

15 Q Are there any individuals on this client review team who
16 cannot prescribe medications?

17 A Yes.

18 Q Doctor, I'm going to refer to the client review team as the
19 CRT. Would that be okay?

20 A Okay.

21 Q Thank you. You testified yesterday that DOJ gave you the
22 four questions that the CRT members were to answer in this
23 case. Is that correct?

24 A Yes.

25 Q Did the CRT meet for two days as a team in January 2018 in

1 Washington, DC?

2 A Yes.

3 Q Was that meeting at the Department of Justice?

4 A Yes.

5 Q Was anyone from the Department of Justice present at those
6 meetings?

7 A Yes.

8 Q Who was present?

9 A Several DOJ lawyers were in and out of those meetings.

10 Q During the client review team process, did the CRT hold
11 weekly calls to discuss themes and findings?

12 A Yes.

13 Q Did anyone from the DOJ participate in those calls?

14 A Yes, I think so.

15 Q All right. Now, at various points in time, the CRT --
16 well, let me digress. There are 154 individuals in the sample,
17 and four are deceased? Yes?

18 A Yes.

19 Q And so of the 154, 150 individuals were actually
20 interviewed. Is that correct?

21 A That's close to correct. There were a couple of patients
22 at least who were mute, and so most of the interview was with
23 their families.

24 Q Okay. But at some point, the CRT came to Mississippi and
25 attempted to interview the 150 -- 150 individuals?

1 A Well, we attempted to interview the 299, but we did
2 interview 150.

3 Q Okay. And they're the individuals discussed in your
4 report. Correct?

5 A Yes.

6 Q So I'm talking about those individuals. When DOJ -- excuse
7 me. When the CRT interviewed or attempted to interview the 150
8 individuals, did any of the DOJ lawyers participate in those
9 interviews?

10 A They attended the interviews. They were driving us around
11 Mississippi to find people, and when we found the person, the
12 DOJ member would explain why we were there and I think would go
13 over the consent issues, but then the CRT members, as you call
14 us, were the interviewers.

15 Q All right. As Mr. Holkins went over with you a few minutes
16 ago, in your report you wrote that community-based services are
17 scarce or nonexistent in Mississippi. Is that correct?

18 A Yes.

19 Q All right. Do you know what community-based services are
20 allegedly nonexistent in Mississippi?

21 A Again, this is based on the 154 people in our sample.
22 Right.

23 Q So I think, as you said, your conclusion that
24 community-based services are scarce or nonexistent in
25 Mississippi is based only on the survey of the 154 individuals

1 in the CRT sample?

2 A Yes.

3 Q Did you survey every region of Mississippi?

4 A I did not.

5 Q Did you survey every CMHC in Mississippi, community mental
6 health center?

7 A No.

8 Q Did you survey every community-based service that's
9 available in Mississippi?

10 A Not as part of this process.

11 Q The conclusions that the CRT came to regarding the 154
12 individuals, did they arrive at those conclusions in 2018?

13 A Yes, I think so.

14 Q All right. So as you testified yesterday, the conclusion
15 of the CRT is that 100 percent of the sample would have avoided
16 or spent less time in a State Hospital if they had received
17 reasonable community-based services. Is that correct?

18 A Yes.

19 Q All right. And the CRT members made those determinations,
20 as you just said, in 2018?

21 A Yes.

22 Q So, for example, if one of the individuals had a hospital
23 admission in, say, 2005, the CRT concluded in 2018 that they
24 would have avoided or spent less time in the hospital at -- in
25 2005, if they had received community-based services back then?

1 A Yes.

2 Q And that applies to whatever year the admission occurred
3 in. Is that correct?

4 A I think I follow your reasoning.

5 Q Yeah. So if you had a 2015 admission, in 2018, DOJ --
6 excuse me, the CRT concluded that with reasonable
7 community-based services that admission would have been
8 avoided, or they would have been admitted but would have spent
9 less time?

10 A Yes.

11 Q All right. Yesterday you said something to the effect that
12 we are at a very primitive stage in psychiatry. Do you recall
13 that testimony?

14 A Yes.

15 Q All right. I want to ask you a little bit about that. Is
16 our understanding of the brain very early and incomplete
17 compared to the rest of the body?

18 A Yes.

19 Q And why is that?

20 A The brain is much more complicated than other organs in the
21 body. Just to give you an example, the human genome project,
22 which has been studied closely for the last decade, has come up
23 with very surprising findings about mental disorders that we
24 didn't expect at all, and it has to do with just the early
25 stage of the science of brain functioning and chemistry and

1 genes and expression and so on.

2 Q Depending on the severity of the mental illness, can mental
3 illnesses be incredibly complex and difficult to treat?

4 A Yes.

5 Q Doctor, just to -- before I leave this topic, talking about
6 the human genome and whatnot, let's talk about DNA for a
7 second. Is there some emerging literature to the effect that
8 based on an individual's DNA, determinations can be made about
9 what antipsychotic medications may be most effective for that
10 individual?

11 A There are papers on that, but I believe the latest data,
12 including an editorial within the last two weeks, say that they
13 are not scientifically valid.

14 Q So we're not quite to that point in medical science at this
15 time?

16 A Correct.

17 Q Let me -- I just want to briefly touch on polypharmacy,
18 because you gave some testimony about that yesterday. Is it
19 your testimony that a clinician can never exceed the
20 recommended dosage for an antipsychotic medication?

21 A No.

22 Q When individuals have a choice, do some of them choose to
23 stop taking their medications?

24 A Yes.

25 Q Doctor, I want to ask you about that, the tool kit document

1 that's P-1078 in the notebook in front of you.

2 A Yes.

3 Q When you were testifying yesterday, did you call that
4 document the base manual of standards for ACT?

5 A I may have used those words.

6 Q You agree with me that document's 430 pages long?

7 A I haven't counted the pages.

8 Q They're on there.

9 A It looks pretty thick.

10 Q At the bottom. Why does it take 430 pages to explain how
11 to do PACT?

12 A I'm not sure that it always takes over 400 pages. I've
13 seen one-page descriptions, and this document contains a large
14 number of small descriptions that are intended for different
15 purposes, doesn't it?

16 Q The document we're talking about, P-1078, what is SAMHSA's
17 role in that document?

18 A The Substance Abuse and Mental Health Services
19 Administration commissioned us to prepare these documents on
20 core evidence-based practices.

21 Q And at least generally speaking, what is SAMHSA's role in
22 mental health?

23 A Generally speaking, SAMHSA was created when the services
24 division was split off from the National Institute of Mental
25 Health, and it was intended to -- as I remember it, facilitate

1 services in mental health, and it has, to a large extent, been
2 responsible for distributing state block grants.

3 Q Or among other things, people with SMI or serious mental
4 illness?

5 A Yes, sir.

6 Q All right. Do you know what the ISMICC report is?

7 A That's the interagency --

8 Q Yes, sir.

9 A -- report on mental illness? Is that what you're referring
10 to.

11 Q Yes, sir. Are you familiar with that report?

12 A I have read it.

13 Q Let's talk about New Hampshire for a minute. I'm going to
14 refer you, Doctor, to your report, which is Exhibit PX-404, and
15 I believe you have that in front of you.

16 A Yes.

17 Q I'm also going to display -- all right. Doctor, this is on
18 page 3 of your report that I'm directing your attention to the
19 highlighted sentence. Does it read, "In the 1990s, the
20 National Alliance on Mental Illness rated New Hampshire as the
21 best state mental health system in the U.S.?"

22 A Yes.

23 Q Do you hold New Hampshire's mental health system out as a
24 model for Mississippi?

25 A You understand that I haven't worked in New Hampshire for

1 15 years, so I have not kept up with the details of New
2 Hampshire. In the 1990s, New Hampshire was considered a model,
3 but I gather that's changed a lot.

4 Q You work at Dartmouth. Correct?

5 A Yes.

6 Q And Dartmouth, of course, is in New Hampshire?

7 A Yes.

8 Q Do you have any -- on any -- do any of the research project
9 you do or have done over the last 15 years involve the state of
10 New Hampshire?

11 A Very little.

12 Q Look at page four of your report. I'm sorry, Doctor. Page
13 7. All right. Doctor, do you see the highlighted part there?

14 A Yes.

15 Q It talks about in New Hampshire, the single state
16 psychiatric hospital, New Hampshire hospital had 2700 beds in
17 1955, but only 120 beds by the 1990s, when the state mental
18 health system was considered a national model of excellent
19 mental health care. Did I read that correctly?

20 A Yes.

21 Q As we sit here today, does the New Hampshire hospital still
22 exist?

23 A Yes.

24 MR. SHELSON: Your Honor, may I approach the witness?

25 THE COURT: Yes, you may.

1 BY MR. SHELSON:

2 Q Doctor, have you seen Exhibit P-257 (sic) before today?

3 A Have I seen it before today?

4 Q Yes, sir.

5 A No.

6 Q Do you know what the Human Services Research Institute is?

7 A Yes, I know some of those people.

8 Q Do you know what the technical assistance collaborative is?

9 A Yes.

10 Q What is it?

11 A It's a group of mental health people who try to provide
12 technical assistance to states.

13 Q To your knowledge, did they do that in Mississippi at some
14 point?

15 A I don't know about that.

16 Q All right. Would you turn to page 3 of D-257?

17 MR. SHELSON: I'm sorry. It's D-257.

18 BY MR. SHELSON:

19 Q Do you see the highlighted part there?

20 A Yes, I'm reading that.

21 THE COURT: I presume D-257 is one of the agreed to
22 exhibits?

23 MR. SHELSON: No, sir.

24 THE COURT: Huh?

25 MR. SHELSON: No, sir.

1 THE COURT: Oh, okay. Go ahead, then.

2 MR. SHELSON: I haven't offered it yet, Your Honor.

3 THE COURT: Okay. All right.

4 BY MR. SHELSON:

5 Q Have you finished?

6 A Yes.

7 Q All right. Does this indicate that the Department of
8 Health and Human Services in New Hampshire issued a request for
9 proposals for an independent evaluation of the capacity of the
10 current health system?

11 MR. HOLKINS: Objection, Your Honor. Dr. Drake has
12 not seen this document before. He's testified that he's not
13 been keeping up with practices in New Hampshire since the mid
14 2000s. The objection is to the relevance of this.

15 THE COURT: Any response, Mr. Shelson?

16 MR. SHELSON: Yes, sir. There are, Your Honor, at
17 least five reasons why we think this document is relevant.
18 Number one, Dr. Drake discusses the New Hampshire mental health
19 system in his report; number two, he gave some testimony about
20 the New Hampshire mental health system yesterday; number three,
21 at approximately 4:47 p.m. yesterday, Mr. Holkins asked
22 Dr. Drake the following questions. And he was referring to
23 Dr. Drake's findings in Mississippi, but the question was:

24 "Question: How do these findings compare to your work
25 in other states?"

1 This morning, Mr. Holkins asked Dr. Drake, "Have any
2 other stages moved beyond this initial stage of
3 deinstitutionalization?" They've opened the door to the mental
4 health systems in other states.

5 And number five, the mental health systems of other
6 states is relevant to establishing when a public mental health
7 system offers sufficient systemwide -- sufficient services on a
8 systemwide basis to satisfy *Olmstead*.

9 THE COURT: But how is he going to testify about this
10 document that he has not seen before?

11 MR. SHELSON: Well, when I -- I'm laying a foundation
12 for that, but when I get to specifics about New Hampshire, if
13 his answer is he doesn't know, then so be it, but we don't know
14 that until I get to the actual questions.

15 THE COURT: And I guess -- I mean, in his report, he
16 mentions New Hampshire, but it's confined to the period of
17 looks like 1955 up to 1990, and I assume this report here is
18 something that goes up to 2017. I don't know when it starts,
19 but it looks like it's something that evaluates or critiques
20 what's going on in New Hampshire in 2016 and 2017. Right?

21 MR. SHELSON: Yes, sir.

22 THE COURT: Okay. I'll see where you go with it, but
23 I'll note if he cannot testify about what's currently happened
24 there -- we'll see where you go -- where he goes. So right
25 now, the objection is overruled for right now. I'll allow to

1 you continue to make your foundation, Mr. Shelson.

2 MR. SHELSON: Let me see if I can do it without this,
3 Your Honor.

4 BY MR. SHELSON:

5 Q Dr. Drake, to your knowledge, are there any work force
6 shortages in the mental health field in New Hampshire?

7 A Since I left working in New Hampshire, my only knowledge
8 about these issues comes from our local newspaper. I have not
9 done any work in New Hampshire.

10 Q All right. Let me ask you this, and then I'll move on from
11 this document. This is on page -- this map is on page 33. Do
12 you at least know that in New Hampshire, they have CMHCs?

13 A Yes, that was true in the 1990s and 2000.

14 Q And those CMCs are organized by region. Is that correct?

15 A They were in 2000.

16 Q And of the regions -- of the ten regions in New Hampshire,
17 does this map purport to show that there are -- that New
18 Hampshire has mobile crisis response teams in three of the ten
19 regions?

20 A Well, I've not seen this figure before, but that's what it
21 purports to show.

22 Q You can set that document aside.

23 THE COURT: I'll mark D-257 for identification
24 purposes only for your record.

25 MR. SHELSON: Yes, sir.

1 THE COURT: All right.

2 (Exhibit D-257 for ID marked)

3 MR. SHELSON: Can I have D-232? May I approach the
4 witness, Your Honor.

5 THE COURT: Yes, you may.

6 BY MR. SHELSON:

7 Q Dr. Drake, have you seen Exhibit D-232 before today?

8 A Is this the same document that you handed to me when we had
9 a deposition?

10 Q It may be one of them.

11 A Yeah. That would have been the only time I've seen it, if
12 I have.

13 MR. HOLKINS: Your Honor, the United States objects to
14 this document for the same reasons. It post dates Dr. Drake's
15 work in New Hampshire. It's from October of 2016. We objected
16 on their exhibit list when the State shared this document with
17 us.

18 THE COURT: What was the basis of the objection,
19 because I don't have that in -- what was the basis?

20 MR. HOLKINS: The basis of the objection is the
21 relevance of this document.

22 THE COURT: What was the basis in the pretrial order,
23 though?

24 MR. HOLKINS: The same, Your Honor.

25 THE COURT: Relevance?

1 MR. HOLKINS: Yes, Your Honor.

2 THE COURT: Let me hear from you, Mr. Shelson.

3 MR. SHELSON: It would be shows same five reasons,
4 Your Honor, I gave with respect to D-257.

5 THE COURT: Was the defendant questioned about this at
6 his deposition? Is this a document that he was questioned
7 about at his deposition? I know -- I know you've responded to
8 the witness that this may be one of several documents.

9 MR. SHELSON: This particular one, Your Honor, no, he
10 was not.

11 THE COURT: Okay.

12 MR. SHELSON: I'm sorry, Your Honor.

13 THE COURT: No, no. Go ahead.

14 I'm going to sustain the objection as to relevance if
15 it postdates by -- it looks like it's -- it's 2016, 2017, which
16 is, for all practical purposes today -- well, way past the time
17 that was discussed in the report, it looks like.

18 MR. SHELSON: Your Honor, this article -- well, this
19 document is from October 6, 2016. The date is -- the other
20 date is the date it was printed on, but in any event, it is --
21 it's a 2016 document.

22 THE COURT: Okay.

23 MR. SHELSON: I'll move on Your Honor.

24 THE COURT: All right. I'll allow you to mark -- that
25 one will be marked for identification purposes only for your

1 record.

2 MR. SHELSON: Yes, sir.

3 (Exhibit D-232 for ID marked)

4 BY MR. SHELSON:

5 Q Doctor, do you know what the secure psychiatric unit is in
6 New Hampshire?

7 A I'm not sure.

8 Q Do you know whether they have -- do you know whether --
9 that they use cages in New Hampshire for therapy booths for
10 adults with SMI?

11 A I'm not aware of that. I really have almost no information
12 about mental health in New Hampshire since I left.

13 Q If they do, would you approve of that practice?

14 A I would have to know a lot more about the issues and what
15 you're talking about and where this occurs and so on.

16 Q Are there any federal, state and county components to
17 the -- let me redo that. Are there federal, state and county
18 components to the public mental health system?

19 A Yes, sir.

20 Q Are there -- are the federal and state public mental health
21 systems interrelated in all kinds of ways?

22 A Yes.

23 Q Are they interrelated in financing?

24 A Yes.

25 Q Are they interrelated in training?

1 A Yes.

2 Q Are they interrelated in research?

3 A Yes.

4 Q Are they interrelated in many other ways?

5 A Probably many other ways.

6 Q Are the federal and state public mental health systems a
7 complex system?

8 A Yes, I think so.

9 Q Are there any federal mental health policies that are not
10 helpful?

11 MR. HOLKINS: Objection, vague.

12 THE COURT: Objection overruled.

13 A That are unhelpful in terms of what?

14 BY MR. SHELSON:

15 Q Assisting people with SMI.

16 A There are debates about that, but I believe that some of
17 the federal policies are unhelpful.

18 Q Is one of the federal mental health policies that you
19 believe is unhelpful in the area of insurance and disability
20 payments?

21 A Yes.

22 Q Is another example of an unhelpful federal mental health
23 policy that the Social Security Administration policies don't
24 incentivize people to work?

25 A Again, there's lots of debate and research about that, but

1 I believe that the disability policies sometimes interfere with
2 people's ability to get back to work.

3 Q Would you explain why that is?

4 A Well, outside of the military and special programs for
5 Native Americans and a few other groups, I think, the federal
6 disability policies for people with mental illness are two.
7 There's the Social Security Income, and there's Supplemental
8 Security Disability Insurance. They are called SSI and SSDI.
9 And under both policies, the rules about how much a person can
10 work are very complicated so that we actually have to have a
11 benefit specialist on the team to help people understand if
12 they can go to work and how much they can work, because people
13 are afraid that they're going to lose their disability payment,
14 and with it, they may also lose their health insurance by going
15 to work.

16 Q So let's talk a minute about that benefit specialist you
17 just referenced. By that, do you mean that at least some
18 states hire benefits specialists to help people navigate the
19 issues you just described?

20 A Yes.

21 Q All right. So the federal policies you just described are
22 so complicated that some states have had to resort to hiring
23 benefits specialists to help people navigate the system?

24 A I'm not sure your phrase "have to resort to" is correct,
25 but this is a service that's often offered through the

1 Department of Vocational Rehabilitation in states.

2 Q The concern, though, is because the process is so
3 complicated, that adults with SMI cannot navigate that process
4 without assistance?

5 A Yes, many cannot understand it.

6 Q And of course, the bottom line concern is that many adults
7 with SMI are concerned that if they go to work, they will lose
8 certain federal benefits?

9 A Including their insurance, yes.

10 Q And including their health insurance?

11 A Yes.

12 MR. SHELSON: Can I have D-249, please.

13 May I approach the witness, Your Honor?

14 THE COURT: Yes, you may.

15 BY MR. SHELSON:

16 Q Doctor, do you recognize Exhibit D-249?

17 A Yes.

18 Q What is that document?

19 A It's a review article that colleagues and I wrote on case
20 management services.

21 Q And was this article that you coauthored published in 1998?

22 A Yes.

23 Q Would you turn to page 65, please. Doctor, why don't you
24 just read the highlighted part to yourself, and tell me when
25 you're finished.

1 A (Witness complied with request.) Okay.

2 Q First sentence, does it read, "It is becoming increasingly
3 clear that there's no single community care model that is
4 equally appropriate across all service settings"?

5 A Yes.

6 Q Is that still true today?

7 A Yes, I think so.

8 Q Next sentence, "For example, the resources and
9 characteristics of rural communities place different demands on
10 service systems compared to urban communities." Is that still
11 true today?

12 A Yes.

13 Q "Because of smaller numbers of patients served, rural case
14 management teams typically are smaller, have less frequent
15 staff meetings and have less crisis coverage than their urban
16 counterparts." Is that still true today?

17 A Yes, I think so.

18 Q "Social isolation, poverty, social stigma, and lack of
19 qualified mental health workers have all been reported as
20 particularly significant barriers in rural areas." Is that
21 still true today?

22 A Yes, I think so.

23 Q And the last one, "In addition, rural patients may differ
24 diagnostically from urban patients." Do you still believe
25 that's true today?

1 A Yes.

2 Q And why is that, Doctor?

3 A The last point?

4 Q Yes, sir. Why do rural patients -- why may rural patients
5 differ diagnostically from urban patients?

6 A Well, they're often different socioeconomic forces in rural
7 areas. Many people with the most serious illnesses migrate to
8 urban areas because the services are better. There are
9 different types and amounts of drug exposure in rural and urban
10 areas. There are different amounts of family involvement in
11 rural and urban areas. So there are several issues that
12 differ.

13 Q Doctor, to some extent, have you traveled throughout the
14 state of Mississippi?

15 A I'm not sure what you mean "to some extent."

16 Q Have you -- how much of Mississippi have you seen?

17 A I have seen the Jackson area, and I have seen the Delta
18 region, and I have seen the southern and gulf region where my
19 relatives live, but I've not seen everywhere in Mississippi. I
20 would like to.

21 Q Based on your observations, is Mississippi a rural state?

22 A It looks quite rural to me.

23 MR. SHELSON: Your Honor, I move to admit
24 Exhibit D-249 into evidence.

25 THE COURT: Any objection?

1 MR. HOLKINS: No objection, Your Honor.

2 THE COURT: All right. D-249 will be received into
3 evidence.

4 (Exhibit D-249 marked)

5 BY MR. SHELSON:

6 Q Doctor, I want to ask you about deinstitutionalization. Do
7 you note in your report that deinstitutionalization has its
8 critics?

9 A Yes, I think I said that in the report.

10 Q All right. This is page 9 of your report, Doctor, which is
11 PX-404. Let me refer you to the highlighted part. "Many
12 states have closed hospitals but failed to set up
13 community-based services simultaneously." Did I read that
14 correctly?

15 A Yes.

16 Q Is that a problem when states do that?

17 A Yes.

18 Q Why is it a problem?

19 A Well, people who are moved from hospitals to the community
20 without appropriate services struggle quite a bit.

21 Q If a state closes State Hospitals without setting up
22 community-based services simultaneously, is that
23 deinstitutionalizing irresponsibly?

24 A I think so.

25 Q All right. Doctor, the next sentence we're looking at

1 here, you wrote, "Other states established community-based
2 services but failed to sustain them when budget crisis
3 appeared." Did I read that correctly?

4 A Yes.

5 Q What other states are you referring to there?

6 A Well, I think this occurred during the recent recession in
7 many states around the country. I work with teams in about 20
8 states, and this was a -- not New Hampshire, but 20 other
9 states, and this was a common refrain during the recession,
10 that state budgets cut funding to mental health programs.

11 Q It continues that "These failures have undoubtedly
12 contributed to incarceration, homelessness and readmissions
13 among people with serious mental illness." Why is that the
14 case?

15 A Well, if we discharge patients from hospitals without
16 having appropriate housing, and without having appropriate
17 services and supports, and without having insurance, and
18 without having jobs, it's very difficult for them.

19 Q Is the way to deinstitutionalize responsibly to increase
20 community-based services as you decrease State Hospital bed
21 capacity?

22 A Well, there are lots of debates about that. It's walking a
23 fine line. The finding has been that if you close beds before
24 you increase services, then the State may back off from
25 increasing the services, and then you're in a pickle. If you

1 don't close beds and you increase services, then hospitals have
2 a way of finding new populations and filling up, and then
3 you're in a pickle because you're -- you haven't saved money in
4 one place to pay for the services in the other place. Does
5 that make sense?

6 Q Sure. But what you just said, do you agree that that shows
7 that the deinstitutionalization process we're discussing is not
8 a simple process?

9 A I agree with that.

10 Q There's no formula for how you do that. Correct?

11 A It's been done differently in different states.

12 MR. SHELSON: May I have just a moment, Your Honor?

13 THE COURT: Okay.

14 (Short Pause)

15 BY MR. SHELSON:

16 Q Doctor, you talked earlier about cycling through hospitals.
17 Do you recall that?

18 A Yes, sir.

19 Q Did you compare the readmission rates of Mississippi's
20 State Hospitals to the readmission rates of state -- the
21 readmission rates of State Hospitals in other states?

22 A No.

23 Q Doctor, would you please turn to page 11 of your report?

24 THE COURT: Before you turn away from that page,
25 Mr. Shelson, remind the court what page is that of his report.

1 MR. SHELSON: Your Honor, page 9.

2 THE COURT: Okay. Thank you.

3 BY MR. SHELSON:

4 Q All right. Dr. Drake, in your report, PX-404, I'm on page
5 11, and I'm in the crisis service section, and the highlighted
6 sentence reads, "For example, mobile crisis teams which exist
7 in many states include mental health professionals and
8 practitioners who are available 24 hours a day to reach out to
9 people experiencing a mental health crisis in home schools and
10 other locations." Did I read that correctly?

11 A Yes.

12 Q You wrote that mobile crisis teams exist in many states.
13 Does that mean that there are states which have no mobile
14 crisis teams?

15 A You know, I haven't surveyed states about mobile crisis
16 teams. I think that's not what I was asked to do.

17 Q So you don't know one way or the other?

18 A Correct.

19 MR. SHELSON: Your Honor, may I approach.

20 THE COURT: Yes, you may.

21 BY MR. SHELSON:

22 Q Doctor, you're free to look at your deposition for this
23 next question, but this is from page 168 of your deposition,
24 lines 8 through 14. You testified that "There are about
25 10 percent of the people who love peer support services, lots

1 who don't." What did you mean by that?

2 A Page 168, did you say?

3 Q Yes, sir. There have been many studies of peer support
4 services, and I think the general finding has been that about
5 10 percent of the people with serious mental illness use those
6 services regularly. Is that what you're referring to?

7 Well, to be specific, Doctor, I'm referring to this
8 sentence right here. "You know, there are 10 percent of the
9 people who love peer support services, lots who don't." I
10 think you just answered the 10 percent part.

11 A Yes.

12 Q So when you said lots who don't, are you referring to the
13 90 percent of people with SMI that -- are you saying that
14 90 percent of adults with SMI do not find peer support services
15 helpful?

16 A Well, 90 percent don't use them, and I'm confident that
17 some portion of that 90 percent don't find them useful.

18 Q Based on your experience or your review of the literature,
19 do you know why 90 percent of adults with SMI do not use peer
20 support services?

21 A I think I testified yesterday that people with serious
22 mental illness in general do not want to live with other people
23 with serious mental illness. And I'm speculating that that
24 also explains why the majority of people don't use peer support
25 services. But I don't really know the answer.

1 MR. SHELSON: Your Honor, may I approach.

2 THE COURT: Yes, you may.

3 BY MR. SHELSON:

4 Q Doctor, do you recognize Exhibit D-235?

5 A Yes. Could I ask you a question, Mr. Shelson?

6 Q Yes, sir.

7 A Would it be possible to take a bathroom break.

8 THE COURT: Yes. Yes.

9 THE WITNESS: Thank you very much, Your Honor.

10 THE COURT: We'll take a -- it's a good time to take a
11 15-minute break anyway. We'll take a 15-minute break, and
12 we'll just resume up at 10:45. Thank you. We're in recess.

13 (Recess)

14 THE COURT: You may proceed whenever, Mr. Shelson.

15 Oh, Dr. Drake, no need for him to proceed without you.

16 BY MR. SHELSON:

17 Q Dr. Drake, the document that you're looking at now, Exhibit
18 D-235, did you prepare this document in connection with this
19 case?

20 A Yes.

21 Q Is this the document where you reviewed the literature and
22 determined how effective certain community-based services are
23 at reducing hospitalizations?

24 A Yes. This is one version of it for sure.

25 Q Okay. So over here to the right, is this where you -- so,

1 for example, diversion 50 percent, that means you found that
2 diversion -- that 50 percent is the hospital reduction rate for
3 diversion. Is that correct?

4 A It means that the latest systematic review that we were
5 able to find concluded that.

6 Q All right. And obviously, where it says -- and I've
7 highlighted a number of them here, for example, "case
8 management, lack of data," in your review of the literature,
9 you found no data on how effective case management is at
10 reducing hospitalization?

11 A Not sufficient data for us to make a conclusion. There's
12 only one randomized controlled trial of peer support in
13 relation to the hospital reduction, for example.

14 Q Where it says -- Doctor, do you see the sentence above the
15 heading summary that I've highlighted here?

16 A Yes.

17 Q All right. Where it says, "Few, if any, studies have
18 addressed combined effects," by that do you mean if you, for
19 example, combined assertive community treatment with case
20 management, there's not studies of that nature?

21 A It's complicated. Assertive community treatment often
22 combines some of these other services as a bundled package, but
23 it's generally true that there are not many studies that have
24 put several evidence-based practices together and then
25 determined what's the effect on hospitalization.

1 Q For substance abuse treatment, you said it's unclear?

2 A Yes.

3 Q Why is it unclear?

4 A Because it usually hasn't been measured. Most of the
5 studies of substance abuse treatment or co-occurring substance
6 abuse treatment focused on the abstinence or reduction of
7 substance use and the effects on symptoms, but they don't
8 measure hospitalization.

9 Q Is the bottom line that community-based services are
10 effective at helping some people but not all people avoid
11 hospitalization?

12 A I think that's a fair summary. We -- again, you know,
13 there are no studies where somebody's really put all of these
14 interventions together to see what would be the combined
15 effect.

16 Q And the degree to which a particular community-based
17 services reduces hospitalization is summarized on
18 Exhibit D-35 -- 235?

19 A Is that the page we're looking at here at the top?

20 Q Yes, sir. Yes, sir.

21 A Yes.

22 MR. SHELSON: Your Honor, I apologize. I don't
23 remember if I did this before the break, but in any event, I
24 move to admit D-235 into evidence.

25 THE COURT: Any objection?

1 MR. HOLKINS: No objection, Your Honor.

2 THE COURT: D-235 will be received into evidence.

3 (Exhibit D-235 marked)

4 BY MR. SHELSON:

5 Q Doctor, you testified yesterday that, or words to this
6 effect, "Variability across the country is really amazing from
7 state to state and region by region." What did you mean by
8 that?

9 A Was I testifying in relation to evidence-based practices?

10 Q Yes, sir.

11 A Of course, I don't know every state well, but I do some
12 work in about half of the states, and we did a national survey
13 of supported employment in all states. So that's the only
14 state where I really have national data. But there's -- across
15 states, there is tremendous variability. There's states --
16 well, you don't need examples. The answer is yes.

17 Q One of the issues in this case is whether services are
18 uniformly available. Are you familiar with that concept?

19 A Well, you and I discussed it before, and I looked it up to
20 make sure I would understand what it means.

21 Q Do you now know what it means?

22 A Yeah. All the definitions referred to statistical and
23 physical properties.

24 Q Well, let me cut --

25 A I assume that what you mean by it is an even distribution

1 across different regions of a state. Is that correct?

2 Q I'm more concerned what DOJ means by it.

3 A Okay.

4 Q You're one of their experts. So here's the question.

5 A Okay.

6 Q Do you have an opinion on what it means to have services
7 uniformly available throughout a state?

8 A Yes.

9 Q What is your opinion?

10 A I've done a lot of work in New Hampshire and Vermont,
11 which, by the way, is the most rural state in the country, and
12 I know that it's difficult to have the same quality of services
13 across a state.

14 Q Do you agree with me that no public mental health system
15 can deliver community-based services in a manner that is truly
16 uniform?

17 A You know, again, that depends on what we're going to mean
18 by uniform. I think if we're referring to quality rather than
19 the specific form of services, that that's what states aspire
20 to.

21 Q Do you agree with me, since you're from New Hampshire, that
22 if I go visit New Hampshire and I have a heart attack, I'm
23 going to be treated for that heart attack more quickly in some
24 parts of New Hampshire than others?

25 A Yes, I'm sure that's true.

1 Q Does the same concept apply to community-based services?

2 A I think that there's what's called regional variation in
3 all medical and social services in this country.

4 Q So when one talks about making community-based services
5 uniformly available, that's not a concrete concept, is it?

6 A Well, you and I haven't agreed on a definite definition.

7 Q Which is -- which -- well, let me just give you an example.

8 If because of geographic distance from where the service is
9 located, say a mobile crisis team, if that service is available
10 in the region, some people are going to be further away from
11 the service than others. Is that correct?

12 A Yes, I think so.

13 Q So in my example, it may take 20 minutes for a mobile
14 crisis team to get to an individual and maybe 30 minutes to get
15 to somebody else. Is that fair?

16 A That's what it says in the Mississippi criteria for
17 services.

18 Q And in my example, if it took longer to get to somebody
19 because they live further away from the service, does that mean
20 that the service is not uniformly available?

21 A You keep assuming I know what you mean by uniformly
22 available.

23 Q Let me ask it this way.

24 A Okay.

25 Q Do you know what the DOJ means by uniformly available in

1 this case?

2 A No.

3 Q All right. I'll move on. Doctor, did you cite what's
4 called "The President's New Freedom Commission Report" on page
5 8 of your report?

6 A Yes, I think so.

7 MR. SHELSON: Your Honor, may I approach the witness.

8 THE COURT: Yes, you may.

9 BY MR. SHELSON:

10 Q Is document D-195 a copy of the New Freedom Commission
11 Report on mental health?

12 A Yes, it appears to be.

13 Q And this is a 1993 report. Is that correct? Excuse me.
14 It's a 2003 report.

15 A Yes.

16 Q All right. And this first page we're looking at is a
17 letter to the President of the United States at that time.
18 It's dated July 22, 2003. Is that correct?

19 A Yes.

20 Q All right. Do you see the highlighted part there? That
21 first sentence that's highlighted, "Yet for too many Americans
22 with mental illnesses, the mental health services and supports
23 they need remain fragmented, disconnected and often inadequate,
24 frustrating the opportunity for recovery." Do you still
25 believe that's true today?

1 A I haven't surveyed every state, but I believe to different
2 degrees, that's true across states and regions.

3 Q Next sentence reads, "Today's mental health care system is
4 a patchwork relic, the result of disjointed reforms and
5 policies." Do you still think that's true today?

6 A Patchwork relic? I'm not really sure.

7 Q Okay. Would you turn to page 50, please.

8 A Page 50. Okay.

9 Q Do you see the part I've highlighted that's captioned,
10 "Rural America needs improved access to mental health
11 services"?

12 A Yes.

13 Q "The vast majority of all Americans living in underserved
14 rural and remote areas also experience disparities in mental
15 health services." To your knowledge, is that true as we sit
16 here today?

17 A I don't really know. There have been huge changes in the
18 last 16, 17 years, since this was written. I know that, for
19 example, telemedicine and other interventions are widely used
20 to improve services in rural areas.

21 Q I want to skip down to the sentence that reads, "Despite
22 these proportions, rural issues are often misunderstood,
23 minimized and not considered in forming national mental health
24 policy." Is that consistent with your experience?

25 A You know, I wasn't asked that question as part of this

1 process, and I really don't have a data-informed opinion about
2 that.

3 Q Okay.

4 MR. SHELSON: Your Honor, I move to admit Exhibit
5 D-195 into evidence.

6 THE COURT: Any objection?

7 MR. HOLKINS: No objection, Your Honor.

8 THE COURT: D-195 will be received into evidence.

9 (Exhibit D-195 marked)

10 MR. SHELSON: Your Honor, may I approach the witness?

11 THE COURT: Yes, you may.

12 BY MR. SHELSON:

13 Q Doctor, is Exhibit D-253 an article that you're an author
14 of?

15 A Yes.

16 Q Is the -- is this document a published paper?

17 A Yes.

18 Q Is it entitled "Lessons learned in developing community
19 mental health in North America"?

20 A Yes.

21 Q All right. And the part here, does that indicate it was
22 published in *World Psychiatry* in 2012?

23 A Yes.

24 Q All right, sir. Will you please turn to -- it's page 2 of
25 the document. It's page 48 of the article.

1 A Uh-huh.

2 Q All right. You see here where it's highlighted,
3 "Approximately half of all people with severe and persistent
4 mental illnesses in the United States have received no mental
5 health services in the past year, often because they have
6 rejected the available services."

7 A Yes.

8 Q That was your finding in 2012?

9 A Well, that was the finding in reference number 21, which
10 we've cited there. And I think that that's been the general
11 finding of epidemiologic studies in the United States.

12 Q True, as we sit here today?

13 A I haven't seen any evidence to contradict that in the last
14 few years.

15 MR. SHELSON: Your Honor, we move to admit
16 Exhibit D-253 into evidence.

17 MR. HOLKINS: No objection, Your Honor.

18 THE COURT: All right. D-253 will be received into
19 evidence.

20 (Exhibit D-253 marked)

21 MR. SHELSON: Your Honor, may I approach the witness.

22 THE COURT: Yes, you may.

23 BY MR. SHELSON:

24 Q Doctor, do you recognize Exhibit D-256?

25 A Yes.

1 Q What is Exhibit D-256?

2 A It's a short essay from *Psychiatric Services* in 2011.

3 Q Are you the author of that essay?

4 A I'm one of the authors, yes.

5 Q You're one of the authors of it. I'm sorry. What year did
6 you say this was?

7 A It was published in 2011.

8 Q Okay. Do you see this -- the first part I've highlighted,
9 "In an article in this issue, Pogoda and colleagues make
10 several excellent points regarding barriers that impede the
11 dissemination and implementation of evidence-based supported
12 employment within the Department of Veterans Affairs health
13 care system. We have encountered similar barriers within the
14 federal/state public health systems." Did I read that
15 correctly?

16 A Yes.

17 Q Doctor, specifically, when you said you've encountered
18 similar barriers within the federal/state public health care
19 systems, what barriers were you referring to?

20 A Barriers that they cited in the Pogoda article. And I
21 can't remember exactly which ones they highlighted in their
22 article.

23 Q I'll move on then. Let me move on to the next paragraph
24 that's highlighted. "Unfortunately, a much larger barrier
25 prevents the adoption of evidence-based supported employment.

1 The crux of the matter is our failure to develop a clear,
2 simple direct funding mechanism. No single agency funds IPS
3 supported employment, and providers must cobble together
4 funding from multiple sources."

5 Let me stop there. What is IPS supported employment?

6 A That's the evidence-based approach to helping people with
7 mental illness to find and succeed in employment.

8 Q And the issue you were writing about at the time of this
9 article is there was not a direct funding mechanism for IPS
10 supported employment?

11 A Yes.

12 Q As we sit here today, is there a direct funding mechanism
13 for IPS supported employment?

14 A It's better, but it's still too complicated.

15 Q What do you mean by that?

16 A Well, CMS, the Center for Medicare and Medicaid Services,
17 which funds most of the services for public mental health
18 system, they have adopted various waivers and other mechanisms
19 so that it's easier for states to use Medicaid to fund
20 employment services, but it could be even better.

21 Q And it could be even better -- strike that. The source of
22 making it even better is the federal level?

23 A It's complicated because most states that implement IPS
24 supported employment use a combination of funds, some from the
25 federal sources, some from state sources, and some from local

1 sources, but it would be ideal if Medicaid just paid for it as
2 a core service.

3 Q Would you endorse Medicaid doing that?

4 A Yes.

5 Q Let me shift gears to PACT, Doctor, if I may. Is PACT
6 appropriate for individuals who experience the most intractable
7 symptoms of severe mental illness and the greatest level of
8 functional impairment?

9 A Yes. If we're talking about the population of people with
10 serious mental illness, that's true.

11 Q All right. So when we say the most intractable symptoms,
12 can you give us an example of that?

13 A There -- there's a large proportion of people with serious
14 mental illness who do not respond to medications. Various
15 estimates are that it's somewhere between one-third and
16 one-half. So that's a lot of people.

17 And -- but most of those people can nevertheless learn to
18 control symptoms and function at a much higher level in the
19 community, and assertive community treatment is one of the main
20 services that we use for that population.

21 Q And are -- individuals with intractable symptoms tend to be
22 more difficult to treat?

23 A Sometimes they are, although not always. I've treated many
24 patients who have ongoing symptoms and, you know, work
25 full-time and function at a very high level.

1 MR. SHELSON: Your Honor, may I approach the witness?

2 THE COURT: Yes, you may.

3 BY MR. SHELSON:

4 Q Doctor, do you recognize Exhibit D-250?

5 A Yes.

6 Q Is Exhibit D-250 a published paper that you're one of the
7 authors of?

8 A Yes.

9 Q Is the subject of the article assertive community
10 treatment?

11 A Yes.

12 Q Could you turn to the second page of the article, which
13 is -- second page of the document. It's page 76 of the
14 article. The first highlighted paragraph, "Another
15 perspective, however, is to question the long-term viability of
16 the fundamental ACT model." All right. Doctor, what is the
17 fundamental ACT model?

18 A Assertive community treatment was developed a long time
19 ago, in the late 1970s. And it's been modified in many
20 different ways in different places over the years. And so
21 if -- I'd have to reread this article to refresh my memory, but
22 if we mean the original model as the fundamental ACT model, I
23 would say that it has been changed many, many times over the
24 years.

25 Q Has it also been modified for rural areas?

1 A Yes.

2 Q What are the natures -- what is the nature of the
3 modifications to the original PACT model for rural areas?

4 A Yes. The original model was designed in an urban area in
5 Wisconsin, and it assumed that a team of about ten clinicians
6 would be responsible for a group of about 100 patients with
7 serious mental illness. In rural areas, we don't have 100
8 patients with serious mental illness, and we don't have teams
9 that are that large either. So we've needed to do a number of
10 things to modify the model. I mean, and most of those have to
11 do with serving a smaller number of patients with a smaller
12 number of clinicians. So, you know, I've worked in rural areas
13 myself for years and years.

14 Q And in your opinion, is modifying the original PACT model
15 to accommodate rural areas acceptable?

16 A Yes. I know when I was monitoring the teams in New
17 England, we had very good outcomes, often the best outcomes in
18 rural areas.

19 Q Moving on to the second paragraph that's highlighted here,
20 "Two antithetical answers portray the chaotic, diverse and
21 inconsistent state of the U.S. public mental health system. On
22 the one hand, in some state and county systems, basic
23 principles of ACT, such as continuity of responsibility and
24 working in the community to help people learn the skills they
25 need to succeed in roles of their choice, have been

1 incorporated by all community mental health teams as usual
2 care." Is that an example of one way in which ACT has you
3 involved from the original model?

4 A Not really. It's an example of how the principles of
5 evidence-based practices have influenced other treatment
6 approaches in the community.

7 Q Okay. The next sentence, "In these settings" -- to be
8 clear, when you say "In these settings," what are you referring
9 to?

10 A Well, let me see if I can explain it by an example. Back
11 in the 1970s and '80s, and '90s too, really, you had a group of
12 patients who would get assertive community treatment, and then
13 the other patients would get office-based treatment. And
14 what's happened over the years -- and this is what generally
15 happens with evidence-based practices -- is that some of the
16 principles of assertive community treatment, you know,
17 influence the rest of the care system so that all of the teams
18 in many mental health centers do their work as a team and do
19 their work predominantly out in the community and do their work
20 in terms of integrating disciplinary care.

21 Q So back to this sentence, "In these settings, as in
22 European countries with more integrated systems of care, ACT
23 services offer little or no statistical averages in producing
24 better outcomes, and almost certainly no advantages in quality
25 of interaction." Did I read that correctly?

1 A Yes.

2 MR. SHELSON: Your Honor, I move to admit
3 Exhibit D-250 into evidence.

4 THE COURT: Any objection?

5 MR. HOLKINS: No objection, Your Honor.

6 THE COURT: D-250 will be received into evidence.

7 (Exhibit D-250 marked).

8 MR. SHELSON: Your Honor, may I approach the witness.

9 THE COURT: Yes, you may.

10 BY MR. SHELSON:

11 Q Dr. Drake, do you recognize Exhibit D-251?

12 A Yes.

13 Q Is this an article you're the coauthor of entitled "The
14 Critical Ingredients of Assertive Community Treatment"?

15 A Yes.

16 Q If you look down at the bottom right, does this indicate
17 that this article was published in *World Psychiatry* in
18 June 2015?

19 A Yes.

20 Q Would you turn to page 2 of the document, please. The
21 highlighted sentence reads, "ACT is not well suited to rural
22 settings because sparsely populated communities lack a critical
23 mass of service users requiring intensive mental health
24 services."

25 A Yes.

1 Q Is -- is that true as we sit here today?

2 A Well, this pertains to your previous question about ACT.

3 You know, it does need to be modified considerably in rural

4 areas, but it seems to be equally effective in rural areas.

5 Q As modified?

6 A As modified, yes, sir.

7 MR. SHELSON: Your Honor, we move to admit

8 Exhibit D-251 into evidence.

9 THE COURT: Any objection?

10 MR. HOLKINS: No objection, Your Honor.

11 THE COURT: D-251 will be received into evidence.

12 (Exhibit D-251 marked)

13 MR. SHELSON: May I approach the witness, Your Honor.

14 THE COURT: Yes, you may.

15 BY MR. SHELSON:

16 Q Doctor, I've just handed you Exhibit P-417. Do you

17 remember looking at this map yesterday?

18 A I think we looked at it this morning.

19 Q You're probably right. This morning. All right. I've

20 taken the liberty of writing numbers on this map. And I wrote

21 a number wherever there's not a red dot. Do you see that?

22 A Yes.

23 Q And -- well, let me back up. What does -- what does a red

24 dot on this map signify?

25 A I think it stands for one individual in the client review

1 who -- for whom ACT was recommended but lived in a region where
2 ACT was not available.

3 Q Well, is it your understanding of this map that the areas
4 shaded in green are where PACT is available?

5 A Yes. That's what the legend says.

6 Q Okay. Do you know one way or the other whether the areas
7 shaded in green on Exhibit P-417 are some of the most densely
8 populated areas of Mississippi?

9 A I wouldn't be an expert on that at all.

10 Q Okay. Fair enough. I want you to direct your attention to
11 these -- this cluster of four counties here, Smith, Jasper,
12 Covington and Jones. Do you agree with me there's no red dots
13 in any of those four counties?

14 A Yes.

15 Q All right. So based on your experience in the client
16 review sample, do you think it would make sense to put a PACT
17 team in each of those four counties?

18 A I'm not sure you understand statistical sampling. You
19 know, we reviewed only 154 out of 3,000 people, and so we may
20 not have gotten an ACT -- I don't think this would represent --
21 that you could interpret this as saying that there are few or
22 no people who need the service in these counties just because
23 people didn't happen to come up in our sample.

24 Q When you say I probably don't understand statistical
25 sampling -- since I can't even say it, I'm not going to fight

1 you on that. So let me -- you're right, I may be confused,
2 then. Are you saying that the sample that -- of the 154
3 individuals is or is not generalizable to the state of
4 Mississippi as a whole?

5 A That will be a great question for you to pose to Dr.
6 MacKenzie, but what I'm saying is, 154 is only 1/20th of the
7 population that we sampled from. And so in selecting
8 1/20th and then looking at this number of counties, which is
9 41, it's highly likely that the dots in one or more of these
10 counties is unrepresentative or not accurate.

11 Q Well, so are we able then to draw -- I mean, on the one
12 hand, it seems that this map is being used to say that there
13 are areas in Mississippi where there should be more PACT
14 services. Do you agree with that?

15 A I think it was used to show that we -- our sample
16 identified people who were distributed all over the state, and
17 yet there were ACT teams available only in a few specific
18 regions.

19 Q But you agree, based on your sample, that there are, by
20 my -- well, by my count, there are 38, if I'm wrong -- but
21 let's assume I'm right, that there are 38 counties in
22 Mississippi where there's no red dot?

23 A Yes, I see that.

24 Q Okay. So based on your knowledge of statistical sampling,
25 does the data depicted on Exhibit P-417 tell us anything about

1 the degree to which we need PACT services in any of the
2 counties in Mississippi?

3 A I think we would need a lot more data to make that
4 determination. You know, from my brief study of the regions of
5 Mississippi, many of these regions are largely national
6 forests, aren't they?

7 MR. SHELSON: If Your Honor will let me answer the
8 question.

9 BY MR. SHELSON:

10 Q I don't think I can answer your question. I'm sorry.

11 A Sorry.

12 Q But had you finished your answer?

13 A Yes.

14 Q You can set that document aside.

15 MR. SHELSON: May I approach the witness, Your Honor.

16 THE COURT: Yes, you may.

17 BY MR. SHELSON:

18 Q Good news, Dr. Drake, last document.

19 MR. SHELSON: Your Honor, just so the record is clear,
20 P-417 was previously admitted into evidence.

21 THE COURT: Thank you.

22 BY MR. SHELSON:

23 Q All right. Dr. Drake, I put up here on the screen
24 Exhibit D-320, and this is a bar graph of -- the orange bar
25 graph is the number of living individuals who each member of

1 the CRT reviewed, and the blue is how many of those individuals
2 the CRT member recommended PACT services for.

3 A Yes.

4 Q Okay. So, for example, you reviewed seven individuals, and
5 you recommended PACT for one. Is that correct?

6 A Yes.

7 Q And that's 14 percent?

8 A That sounds about right.

9 Q Okay. I'll represent to you that the parties have agreed
10 that -- they can correct me if I'm wrong, but the parties have
11 agreed that the data on this slide is accurate. Okay?

12 A Yes.

13 Q So it ranges from you, at 14 percent, to Dr. VanderZwaag at
14 81 percent. Do you see that?

15 A Yes.

16 Q Why is there such a wide range?

17 A Well, speaking again in terms of statistics, you would have
18 to throw out my data because of the small sample size and what
19 I described yesterday that by the luck of the draw, I had some
20 very idiosyncratic cases in my seven. Then if you look at the
21 other five, you have a range from 57 to 81 percent. So that
22 means that you would have a mean of about 65 percent, somewhere
23 around there and --

24 Q Very close.

25 A You -- and this is the kind of distribution you would

1 expect in a -- it's -- we call it a normal distribution. So in
2 almost any human phenomena, if you draw a sample of people by
3 chance, they're not all going to be in the middle. They're
4 going to be displayed with some at the high end and some at the
5 low end.

6 Q Page 2 of the document you're holding, D-320, is on the
7 screen now.

8 A Yes.

9 Q And 100 of 150, 66 percent. Do you know of any state which
10 provide PACT to 66 percent of the individuals that discharges
11 from the State Hospitals?

12 A You know, that's outside the range of my scope on this
13 study. I haven't surveyed states in relation to ACT services.

14 Q So you don't know?

15 A Right.

16 Q Do you know how many PACT teams Mississippi would need to
17 provide PACT to 66 percent of the people it discharges from
18 State Hospitals?

19 A I believe at the deposition, you told me the number would
20 be 28.

21 Q Well, I don't think I can testify. Do you know?

22 A No, I haven't calculated that. I wasn't asked to do that.

23 Q Do you know how much it would cost to provide PACT services
24 to 66 percent of the people discharged from Mississippi State
25 Hospitals?

1 A No, I wasn't asked to do that.

2 Q You can set that aside, Doctor. Would you look at your
3 report, please, and I'm going -- in the bottom right there, the
4 pages are numbered whatever of page -- whatever of 125. Would
5 you turn to page 35 of 125?

6 A Page 35?

7 Q Of 125, yes, sir.

8 A Yes.

9 Q Is this a summary of your findings regarding person 148?

10 A Yes.

11 Q Would you turn, please, to page 36 of 125.

12 A Yes.

13 Q Did you recommend a small home in the intellectual
14 disability system for person 148?

15 A Yes, I believe I did.

16 Q All right. What type of housing is a small home in the
17 intellectual disability system?

18 A Well, in the states where I've worked, the IDD system often
19 has housing for two or three people with full-time behavior
20 staff, behavioral management staff.

21 Q Is that -- is that kind of housing the same thing as
22 permanent supported housing?

23 A No.

24 Q Is it scatter site housing?

25 A Well, these small units are often scattered throughout a

1 community, but I think that the goal in these small units,
2 these are -- people with intellectual disabilities often have
3 behavioral dyscontrol syndromes, like this fellow, and the IDD
4 specialists use applied behavioral analysis to try to help them
5 learn to control those behaviors before they would be ready to
6 live more independently.

7 Q Let me see if I understood your testimony from yesterday.
8 Do you recall testifying that most patients don't like group
9 homes or congregate living?

10 A Yes.

11 Q All right. And you distinguish group homes from permanent
12 supported housing, or PSH. Is that correct?

13 A Yes.

14 Q Did you describe PSH as scatter site housing?

15 A Yes, in most cases it is.

16 Q Okay. So in this sense that you used scatter site housing
17 in your testimony yesterday as a small home in the intellectual
18 disability system scatter site housing?

19 A It's not a perfect classification, you know, between group
20 homes and scatter site housing, and the IDD system has some of
21 these kinds of specialty units that the mental health system
22 generally does not provide.

23 Q In your opinion, are there types of housing that are
24 appropriate for adults with SMI that are not permanent
25 supported housing?

1 A Yes.

2 Q What are some -- what are some samples of such housing?

3 A Well, there's some patients who prefer to live with their
4 families and do well in that setting. There are some patients
5 who, because of very special needs, need -- you know, need to
6 be in other kind of settings, for example, patients that have
7 such severe medical problems that they need around-the-clock
8 medical services, and patients who have such severe co-morbid
9 conditions, like intellectual disability, that they need
10 specialized services.

11 Q Doctor, a small home in the intellectual disability system,
12 how would such a home typically be staffed?

13 A You know, that's really outside of my expertise. I
14 understand that they have -- they tend to have 24-hour staff,
15 but I don't have a large knowledge in that area.

16 Q I'll just ask you one more question. If you don't know,
17 that's fine. But in that type of housing, are there any
18 limitations on whether the person housed there is free to come
19 and go from the facility as they choose?

20 A I think that varies a lot. I was a doctor for the IDD
21 system in my area for several years, and I was really impressed
22 with their ability to individualize housing and staff services
23 and regulations.

24 Q Do you agree that even individuals with SMI who are living
25 in the community, depending on the circumstances, there may be

1 restrictions on their freedom of movement?

2 A There may be for some people. We're not very good at
3 predicting that. I've treated lots of people who left the
4 hospital, and we expected they would need very close
5 supervision, and it turned out they didn't.

6 Q Well, when the housing recommendation for one of the
7 individuals in the 154-person sample is a type of housing that
8 has 24/7 supervision, there is something about that
9 individual's circumstances why 24/7 supervision was
10 recommended. Do you agree with that?

11 A Yes.

12 Q So if you would please turn to page 50 of 125 of your
13 report. Is this person 154?

14 A Yes.

15 Q Does person 154 have a history of inappropriate sexual
16 behavior?

17 A At least -- let me just make sure I have the right client
18 in mind, because the names aren't here, and I'm used to them --
19 thinking of them as names.

20 MR. SHELSON: May I approach the witness, Your Honor.

21 THE COURT: Yes, you may.

22 MR. SHELSON: I'm going to show the witness this
23 individual's name.

24 THE WITNESS: Oh, yes. Yes, got it. Yes.

25 A I remember this fellow.

1 BY MR. SHELSON:

2 Q Okay. So person 154, what is -- briefly or summarize, what
3 is his history of inappropriate sexual behavior?

4 A I believe that about ten years earlier, he, in a very
5 psychotic state, had entered a neighbor's house and was alleged
6 to make some sort of physical or sexual attack on a young
7 woman, I believe a daughter who was in the house.

8 Q Dr. Drake, the next question I'm going to ask you is on
9 page 51 of 125 of your report, the next page.

10 A Yes.

11 Q Is the community-based housing -- strike that. Is your
12 community-based housing recommendation for person 154 close
13 male supervision?

14 A Yes.

15 Q And what type of community-based housing offers close male
16 supervision?

17 A I think small group homes for men and staffed by men.

18 Q And the staffing by men, in this instance, is obviously
19 because of the inappropriate sexual behavior history?

20 A Yes.

21 Q And so, obviously, the group home you just referenced is
22 not permanent supported housing, and it's not scatter site
23 housing?

24 A Yes.

25 Q All right. The housing that you recommended for person

1 154, would that be a locked facility?

2 A Probably would be locked in the evening, and this fellow
3 would probably need to have, you know, somebody with him during
4 the day when you were going out to shop or go fishing or
5 whatever.

6 I should also say that I've seen a large number of people
7 over the years who had a history of a serious assault and then
8 made a good adjustment in the community and never had another
9 assault for -- in their lives and were able to transition to
10 permanent supported housing. So I think this fellow is very
11 unlikely ever to get out of the hospital, for legal reasons,
12 but I don't think we can predict what he's going to be like in
13 the next ten years.

14 Q And, but I'm asking you these questions because you did
15 make recommendations for community-based services, of course,
16 all premised on him getting out.

17 So the next question is, and you may have already answered
18 this, if person 154 were to be placed in the type of housing
19 you've recommended for him, at least for a period of time, when
20 he left the facility, would he have to be escorted by close
21 male supervision?

22 A That's what I would recommend.

23 Q And did you also recommend supported employment for this
24 individual?

25 A Yes.

1 Q All right. In terms of employment, would you foresee any
2 restrictions on person 154's ability to be employed in jobs
3 where he may come into contact with women?

4 A Yeah, probably. The essence of supported employment is
5 finding a job and a job site that fits the person, both in
6 terms of their strengths and also in terms of a job that they
7 enjoy doing and they can succeed in. So, you know, I've seen
8 people who scream at their hallucinations all day but can work
9 in a saw mill because everyone wears ear covers in a saw mill.

10 Q As perhaps person 154 illustrates, do people with SMI who
11 are living in the community encompass a range of independence?

12 A Yes.

13 Q Do you have an opinion regarding whether Mississippi should
14 close any of its four State Hospitals?

15 A Well, I wasn't asked to make a judgment about that, but
16 that would seem to be a rash maneuver.

17 Q Have you reviewed the literature on how many State Hospital
18 beds a mental health system should have?

19 A Yes, I have.

20 Q And did you find that -- well, is there any agreement in
21 the literature on that issue?

22 A No.

23 Q Do you know what percentage of admissions to a State
24 Hospital in Mississippi come from hospitals that are not State
25 Hospitals?

1 A No, nobody gave me those data. I haven't seen those data.

2 Q In your experience, do you have any knowledge of instances
3 where -- well, let me -- strike that. Let me back up. I'm
4 just going to refer to a nonState Hospital. Do you know what
5 I'm referring to?

6 A Well, there are a range of general hospitals and local
7 hospitals and private hospitals and so on.

8 Q That's what I'm referring to when I say nonState Hospitals.

9 Right. In your experience, do you know of any instances
10 where nonState Hospitals move to have individuals civilly
11 committed to a State Hospital?

12 A Yes.

13 Q In your experience, what other reasons some such nonState
14 Hospitals do that?

15 A I guess I've seen that happen for a wide variety of
16 reasons.

17 Q Do -- in your experience, do any of the reasons include
18 that the time for which Medicaid or private insurance will pay
19 for the individual's stay in the nonState Hospital has expired?

20 A Yes. I've seen that.

21 Q And so, in other words, an individual is an inpatient at,
22 say, a general hospital, the period of time that private
23 insurance will cover that stay is expired, and so the general
24 hospital seeks to have that person civilly committed to a State
25 Hospital?

1 A I believe that happens.

2 Q And if that happens in Mississippi and the judge civilly
3 commits the person, then one of the Mississippi State Hospitals
4 is going to have to deal with that person for a period of time.
5 Do you agree?

6 A That's the way I understand that system to work here.

7 Q Doctor, do you know how many PACT teams Mississippi has?

8 A I was told at one point, but I can't recall. I think it's
9 in the range of six or eight.

10 Q Did you make any determination regarding how many PACT
11 teams Mississippi should have?

12 A No, I think you asked me that earlier, and I did not.

13 Q You testified yesterday to I think what you referred to as
14 the core community-based services?

15 A Yes.

16 Q Okay. So you know what -- I'm using that term as you used
17 it yesterday.

18 A Okay.

19 Q Okay. So with respect to any core community-based
20 services, did you make any determination regarding the quantity
21 of those services Mississippi should have?

22 A I was not asked to do that.

23 Q And therefore, you didn't do it?

24 A Correct.

25 Q Did you personally make any determination regarding the

1 degree to which Mississippi offers any community-based
2 services?

3 A Only through the lens of the 154 people that we reviewed.

4 Q But you didn't do it on a systemwide basis?

5 A That's correct.

6 Q Did you make any determinations regarding the locations in
7 which Mississippi should offer its community-based services?

8 A No.

9 Q Is there any state that doesn't have limitations in its
10 mental health system?

11 A Well, states vary a lot, and as we've talked about before,
12 some do much better than others. All have to struggle with the
13 same financing and regulatory and legislative issues.

14 Q Is there any state that doesn't have any limitations in its
15 mental health system?

16 A I doubt it. I haven't surveyed every state, but I think
17 that that's a pretty fair statement.

18 Q Are you aware of any state that has no unmet needs in its
19 public mental health system?

20 A No unmet needs. You know, the only area where I really
21 have broad knowledge about different states is supported
22 employment. And, you know, there are states that do a pretty
23 good job of making supported employment available to the people
24 who would need it. And there are states that do a poor job,
25 and there are states that do very little. So it's variable,

1 but some states actually do a very good job with supported
2 employment.

3 Q Even though states who do a very good job, do you believe
4 there are no unmet needs for supported employment in those
5 states?

6 A Well, because there are always people who are not in the
7 mental health system at all, you know, there are definitely
8 unmet needs everywhere. That's the nature of our health care
9 system in this country.

10 Q Do you know of any states that have no gaps in its public
11 mental health system?

12 A I only know, on a national basis, the supported employment
13 literature.

14 Q In this case, are you offering any opinions regarding what
15 Mississippi needs to do on a systemwide basis to meet the needs
16 of adults with SMI?

17 A You know, I was not asked to address that question. I
18 think there are other expert witnesses that were asked to do
19 that.

20 Q But you didn't do it?

21 A Right.

22 Q And you're not an expert in mental health system design and
23 cost issues?

24 A Not in the cost issues for sure. I have helped lots of
25 states over the years in designing their system, but I have

1 never been the one to handle the cost and fundraising side of
2 it.

3 Q Do you have any opinions on system design issues with
4 respect to Mississippi?

5 A The system design issues that are offered in the operations
6 manual by DMH in Mississippi, I think they're very good.

7 Q Let me try it this way. This is page 174 of your
8 deposition.

9 A Okay.

10 Q Okay. Question at line 4, "How do you determine whether a
11 state has sufficient community-based services to meet the needs
12 of its adult SMI population, or is that outside your area?"
13 What was your answer?

14 A I said, "Yes. I'm not an expert in those areas."

15 Q Okay.

16 MR. SHELSON: Thank you, Doctor. That's all the
17 questions I have.

18 THE COURT: Okay.

19 MR. HOLKINS: Your Honor, we do have some questions
20 for redirect. If Dr. Drake would like, we can take a short
21 five-minute break if the court would permit.

22 THE COURT: How long is your redirect?

23 MR. HOLKINS: No more than ten minutes, Your Honor.

24 THE COURT: Do you need to take a break, Doctor?

25 THE WITNESS: I don't need a break.

1 THE COURT: All right. Mr. Shelson, before you step
2 down, you referred to Defense Exhibit 320, the bar graph. Did
3 you intend to -- was that admitted into evidence?

4 MR. SHELSON: Now that you mention it, Your Honor, and
5 thank you for pointing out my oversight on that. If I may, I
6 would move to admit Exhibit D-320 into evidence.

7 THE COURT: Okay. It's admitted.

8 MR. SHELSON: Thank you, Your Honor.

9 THE COURT: I assume. Any objections from the
10 government?

11 MR. HOLKINS: This is to --

12 THE COURT: D-320.

13 MR. HOLKINS: No objection, Your Honor.

14 THE COURT: All right. It will be admitted.

15 (Exhibit D-320 marked)

16 MR. SHELSON: Thank you, Your Honor.

17 THE COURT: All right.

18 REDIRECT EXAMINATION

19 BY MR. HOLKINS:

20 Q Hi, Dr. Drake.

21 A Hello.

22 Q I want to ask you a few questions about some of the topics
23 that came up during the cross-examination. You were asked
24 about delivering community-based services in rural areas?

25 A Yes.

1 Q You mentioned that assertive community treatment can be
2 modified to meet the needs of rural communities. Is that
3 right?

4 A Yes.

5 Q Is that true for other community-based services?

6 A Yes.

7 Q Could you give some examples?

8 A I've worked for the last 35 years on and off in Vermont and
9 New Hampshire, which are both very rural states. I think
10 Vermont is even more rural than Mississippi, and so we've had
11 to modify all the services that we deliver. You know, the ACT
12 teams are very small. The psychiatric services are generally
13 delivered by telepsychiatry. Everyone worries that there are
14 no jobs in rural areas, and so supported employment won't work,
15 but, you know, it gets modified a bit. We have to pay more
16 attention to arranging transportation and so on. But the
17 results have always been that we do just as well getting people
18 competitive employment in rural areas as we do in urban and
19 suburban areas.

20 One of the advantages of rural areas is that most -- a
21 higher number of patients live with their families, and so
22 it's -- and family provide a lot of the care. And so it's
23 really incumbent upon us to provide family psycho-education in
24 those areas, even more than in urban areas.

25 There are not as many people in rural areas who are

1 homeless, so we don't need to -- generally, we don't have
2 homeless outreach teams. So, you know, you'll just have to
3 respond to the differences in the particular rural area.

4 Right now I'm supervising a bunch of teams in Appalachia,
5 and the patients there have been just overwhelmed by the opioid
6 crisis in rural Appalachia. It's a real tragedy. And so we
7 have had to modify the teams and the services to provide opioid
8 treatment and opioid recovery services. So it varies.

9 Q I'd like to show you one of the exhibits. This is D-235.

10 A Yes.

11 Q Do you remember talking about this document?

12 A Yes.

13 Q And this is a version of your research regarding hospital
14 reduction rates for various community-based services. Is that
15 right?

16 A Yes.

17 Q Regarding substance abuse treatment, you wrote "Unclear
18 variable."

19 A Correct.

20 Q Are you -- does that refer specifically to the absence of
21 randomized controlled studies?

22 A Yes.

23 Q Is there other research, short of a randomized controlled
24 study, regarding possible reduction rate for substance abuse
25 treatment?

1 A There are many different kinds of services. We followed a
2 cohort of people with co-occurring serious mental illness and
3 substance use disorder in New Hampshire over 16 years. And we
4 found that people recovered in different patterns, but in the
5 general finding was that more people were in recovery in
6 different areas every year. And the hospital, you know, rates
7 went down to just about zero over the years for that cohort.

8 You know, and that reminds me of another aspect of rural
9 care that I should have mentioned when we've talked about that.

10 Q What was that aspect?

11 A You know, when I moved from Boston to New Hampshire, I
12 spent the first two or three years saying, Where are the really
13 sick patients? And finally, I realized that -- and there's
14 literature on this too, that dense, noisy, highly populated
15 inner city areas are really very toxic for people who have
16 serious mental illness, and rural areas just have a lot of
17 advantages. I think that's why I was so surprised. And it
18 took me awhile to learn to take advantage of that.

19 You know, we had patients in the area where I was the
20 medical director in New Hampshire who, when they were really
21 psychotic, you know, they would go to a local pond and fish for
22 the day and avoid being around people. Well, you can't do that
23 in the middle of Boston. That person is more likely to be
24 walking down the street talking to himself and be harassed by
25 some kids and maybe punch somebody and end up in jail or the

1 hospital.

2 So, you know, we've been -- there's been a lot of
3 discussion here about the disadvantages of rural areas, but I
4 actually think the advantages outweigh the disadvantages.

5 Q Thank you. Dr. Drake, you were asked about a direct
6 federal funding mechanism for supported employment.

7 A Yes.

8 Q And your testimony was that there is no direct federal
9 funding mechanism for supported employment. Correct?

10 A Well, under some terms of Medicaid waivers, people can bill
11 directly for supported employment or large aspects of it, but
12 it's still not an easy issue, you know.

13 Q Despite the difficulties with a direct federal funding
14 mechanism for supported employment, are states providing IPS
15 supported employment?

16 A Oh, yes, some do very well. There are states that have
17 more than 100 programs and more than 500 employment
18 specialists. A state close by here, which is another
19 relatively poor southern state, South Carolina, does a terrific
20 job.

21 Q Do you know if that state offers supported employment
22 through each of its community mental health centers?

23 A Yes. In South Carolina, I believe they have 17 community
24 mental health centers across the state, and everyone has a
25 supported employment team. So you think if they have an

1 average of four employment specialists, that's 68 specialists
2 providing services for 30 people apiece, so they're really
3 reaching a large proportion of their patients who need that
4 service.

5 Q Dr. Drake, you wrote reports about seven of the individuals
6 in the clinical review. Correct?

7 A Yes.

8 Q And you answered four questions for each of those seven
9 individuals. Correct?

10 A Yes.

11 Q Setting aside the issue of whether seven is large enough to
12 be a sample, do you have confidence in the findings you made
13 regarding those four questions for those seven individuals?

14 A Yes. Those people --

15 MR. HOLKINS: I have no further questions.

16 A Those people are similar to lots of people that I've
17 treated over the years, and I would think any of them would
18 have a chance to do well in the community.

19 MR. HOLKINS: Thank you, Dr. Drake. I have no further
20 questions, Your Honor.

21 THE COURT: I have one question for you, Doctor.

22 THE WITNESS: Yes, sir.

23 EXAMINATION

24 THE COURT: And the government will have an
25 opportunity to do a follow-up, as well as the defendant, based

1 on the question that I've asked.

2 Earlier on in your direct examination, you mentioned
3 that you -- I guess you came to a or saw a group home in North
4 Jackson where men were sitting around in the home, a large
5 group outside of Jackson, all rocking and shaking and drooling,
6 like State Hospital units of the 1970s. You were around then.
7 Some of us -- I mean, I was very young then.

8 THE WITNESS: Yes, sir.

9 THE COURT: Other than *One Flew over the Cuckoo's*
10 *Nest*. You were about to describe it, and you said, Well, no
11 need to. But I do need you to describe the 1970 -- you
12 indicated that it was like the mental health system of the
13 19 -- of the 1970s.

14 THE WITNESS: Yes, sir.

15 THE COURT: If you could just give me a brief
16 description of that.

17 THE WITNESS: Sure. So one of the main reasons for
18 the institutionalization was, back in those days, people would
19 get sent to the State Hospital, and they would be there for
20 decades. And they would be -- because the medications were
21 new, and we didn't know how to use them, they would be grossly
22 overmedicated. So the rocking and shaking and drooling are all
23 results of gross overmedication. And then because the
24 environment was so stagnant, people's skills and personalities
25 and IQs would, you know, generally erode over time. So the

1 psychiatric literature back in the '60s and '70s was often
2 filled with the notion that severe mental illness was a
3 deteriorating dementing illness, like dementia.

4 We didn't realize then that what we were seeing was
5 mostly the effects of bad treatment. And when we started -- I
6 mean, those back -- they were called back wards in those days.
7 And you read *One Flew Over the Cuckoo's Nest*, and there were
8 many books about it and movies made about it, and it was a
9 very, very -- there have been many sad times in the history of
10 mental health. Right? We've done awful things to patients.
11 But that was one of the worst times. And when we moved people
12 into the community, I think we were all surprised by how well
13 some people did.

14 You know, just like the biggest surprise in my career
15 has been when we started closing day treatment centers and
16 people got better rather than worse. And it took me awhile to
17 realize that because in the day treatment center, they were
18 really being treated like incompetent dependent children.
19 Somebody told them what to do every minute of the day. And
20 once they got out on their own, lots of people, you know, found
21 jobs, found activities and just flourished, and we were not
22 good at predicting -- I was not good at predicting, I know,
23 which people were going to do really well.

24 The fellow in my day treatment center that I would
25 have pegged as having the least possibility of doing well

1 without day treatment, because he just sat in a chair all day
2 long and did nothing, when the day treatment center closed, he
3 got a part-time job in a bank. And now, 20 years later, he's
4 still working every day in that bank. He's had all kinds of
5 promotions. He drives a car. He has his own apartment. I see
6 him at the Skyway when I take my kids up there. He's a
7 different person.

8 THE COURT: Okay. Thank you. Any follow-up based on
9 the question that I've asked? Oh, I was going to go to the
10 government -- to the United States first.

11 MR. SHELSON: Yes, Your Honor.

12 THE COURT: Okay.

13 REDIRECT EXAMINATION

14 BY MR. HOLKINS:

15 Q One question following up, Your Honor. Dr. Drake,
16 returning to that personal care home in North Jackson that you
17 remember --

18 A Yes.

19 Q -- do you recall whether or not the individuals you met
20 there, the clients who were living in that personal care home,
21 had been in State Hospitals in Mississippi?

22 A I didn't get to interview all the clients, but I talked
23 extensively with the staff, and I believe what they told me was
24 that all of these people were men with serious mental illness
25 who had been transferred there from State Hospitals.

1 MR. HOLKINS: Thank you, Dr. Drake. That's all, Your
2 Honor.

3 THE COURT: All right. Thank you. Mr. Shelson?

4 RECROSS-EXAMINATION

5 BY MR. SHELSON:

6 Q Dr. Drake, have State Hospitals evolved since the 1907s?

7 A Oh, yes.

8 Q In positive ways?

9 A Many, many positive ways, yes, sir.

10 Q Such as?

11 A Well, my -- one of my close friends is the medical director
12 of New Hampshire Hospital, and so I talk to him frequently and
13 consult with him about patients like the ones we've reviewed
14 here, and it amazes me that the average length of stay there is
15 seven days. You know, they're really able -- they are really
16 very efficient at getting people evaluated and treated and
17 working out discharge plans right away with the local
18 community. We did nothing like that in the 70s.

19 Q So is your view of State Hospitals as they generally
20 existed today is that they're not some evil places that need to
21 be boarded up and closed?

22 A I would never say anything like that.

23 Q Okay.

24 MR. SHELSON: Thank you, Your Honor.

25 THE COURT: All right. Dr. Drake, you may step down.

1 THE WITNESS: Thank you. It's time for our lunch
2 break. It's approximately 12:16. We'll start back up at 1:45.
3 All right. We're in recess.

4 (Recess)

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CERTIFICATE OF REPORTER

I, CHERIE GALLASPY BOND, Official Court Reporter, United States District Court, Southern District of Mississippi, do hereby certify that the above and foregoing pages contain a full, true and correct transcript of the proceedings had in the aforementioned case at the time and place indicated, which proceedings were recorded by me to the best of my skill and ability.

I certify that the transcript fees and format comply with those prescribed by the Court and Judicial Conference of the United States.

This the 5th day of June, 2019.

s/ *Cherie G. Bond*
Cherie G. Bond
Court Reporter